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HOW I DO IT

Continent Gastrostomy

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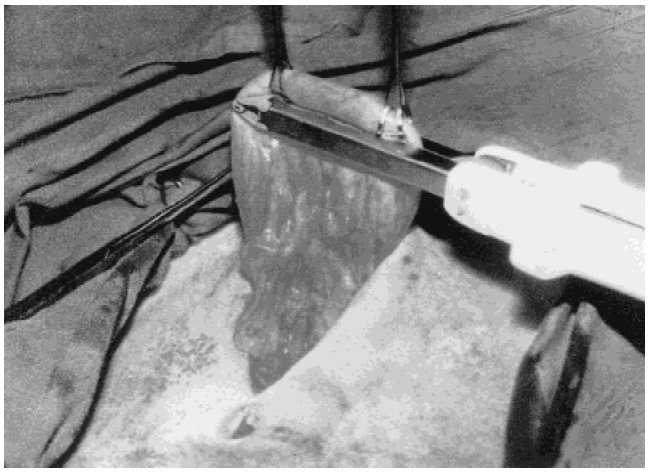

Fig. 1. Creation of the tube from the greater curvature of the stomach.

Fig. 2. The opening of the tube is located at the upper end.

In patients who have a functionally intact gastrointestinal tract but cannot eat, feeding by tube is widely used for long-term alimentation. In recent years, we have witnessed a shift towards percutaneous endoscopic gastrostomy (PEG), replacing the classical operative techniques, i.e., surgical gastrostomy or surgical jejunostomy [1]. However, more recent studies have led to the conclusion that the outcomes do not differ significantly with the placement technique [2,3]. In cases of pathologic conditions of the head and neck or the upper gastrointestinal tract where the insertion of an endoscope is not possible, operative placement of the feeding tube is mandatory [3,4].

Construction of the modified Janeway gastrostomy with the automatic stapler is an easy and fast operative procedure and has two additional advantages over the Stamm gastrostomy. First, it does not require opposition of the stomach to the abdominal wall, and second, the catheter can be removed between feedings. With the assistance of an experienced anaesthesiologist, the operation can be performed under local anaesthesia in < 40 min. The operative procedure is more cost-effective than the Janeway laparoscopic gastrostomy [5], which requires additional skills. The homemade nutritional formula minimises the cost of feeding, and as Kirby et al. [6] stated, "Local expertise and reduction of procedure-related complications should be the major criteria for selecting a technique."

Operative gastrostomy can be performed under local anaesthesia. A senior anaesthesiologist should attend the procedure and sedate the patient satisfactorily. The skin and the abdominal wall are anaesthetised with lidocaine 1%. An upper midline incision 7 cm–10 cm long is made. Once the abdominal cavity is open, the stomach is grasped at the lower portion of the greater curvature and placed on the abdominal wall. The linear cutter (Proximate 75 mm; Ethicon Endo-Surgery,) is positioned so that it is directed at the pylorus (Fig. 1). The instrument is then fired, so as to create a tube from the anterior wall of the stomach with its opening located at the upper end. The stapler line is reinforced with a running 00 vicryl suture (Fig. 2). Additional local anaesthetic is adminis tered before we create a stab wound under the left costal

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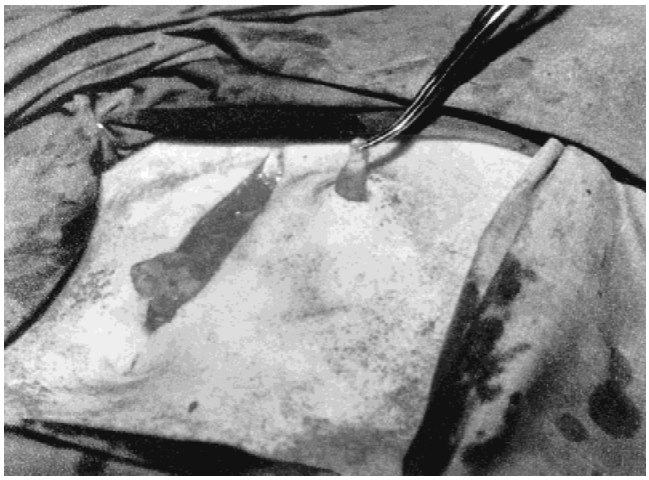

Fig. 3. The opening of the gastrostomy tube below the left costal.

margin, through which we pass the gastric tube to the outside. The abdomen is closed with interrupted sutures and a nipple is created at the end of the tube before the insertion of a 24-French Foley catheter (Fig. 3). A fistulogram is always obtained 48–72 hr after the operation (Fig. 4) before we initiate liquid diet feeding through the catheter. The diet is administered intermittently, and the catheter is removed between meals (Fig. 4).

Fig. 4. Fistulogram 2 days postoperatively.

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